"Substitute per letter dated 10/27/95"

Department of Social Services
Division of Medical Services
Nursing Home Program
Prospective Reimbursement Plan for Nursing Facility Services

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(1) Authority. This plan is established pursuant to the authorization granted to the Department of Social Services (Department), Division of Medical Services (Division).

(2) Purpose. This plan establishes a methodology for determination of reimbursement rates for nursing facilities. Subject to limitations prescribed elsewhere in this plan, a facility's reimbursement rate shall be determined by the Division as described in this plan. Any reimbursement rate determined, by the Division, that has been appealed in a timely manner shall not be final until there is a final decision. Federal financial participation is available on expenditures for services provided within the scope of the Federal Medicaid Program and made under a court order in accordance with 42 CFR 431.250.

(3) General Principles.

(A) Provisions of this reimbursement plan shall apply only to facilities certified for participation in the Missouri Medical Assistance (Medicaid) Program.

(B) The reimbursement rates determined by this plan shall apply only to services provided on or after January 1, 1995.

(C) The effective date of this plan shall be January 1, 1995.

(D) The Medicaid Program shall provide reimbursement for nursing facility services based solely on the individual Medicaid eligible recipient's covered days of care, within benefit limitations as determined in subsections (5)(D) and (5)(M) multiplied by the facility's Medicaid reimbursement rate. No payments may be collected or retained in addition to the Medicaid

reimbursement rate for covered services, unless otherwise provided for in this plan. Where third party payment is involved, Medicaid will be the payor of last resort with the exception of state programs such as Vocational Rehabilitation and the Missouri Crippled Children's Services.

(E) The Medicaid reimbursement rate shall be the lower of:

1. The Medicare (Title XVIII) rate, if applicable; or

2. The reimbursement rate as determined in accordance with sections (11), (12) and (13).

(F) Medicaid reimbursements shall not be paid for services provided to Medicaid eligible recipients during any time period in which the facility failed to have a Medicaid participation agreement in effect. A reimbursement rate may not be established for a facility if a Medicaid participation agreement is not in effect.

(G) When a nursing facility is found not in compliance with federal requirements for participation in the Medicaid program, Sections 1919 (b), (c) and (d) of the Social Security Act (42 USC 1396r), it may be terminated from the Medicaid program or it may have imposed upon it an alternative remedy, pursuant to Section 1919 (h) of the Social Security Act (42 USC 1396r). In accordance with Section 1919 (h)(3)(D) of the Social Security Act, the alternative remedy, denial of payment for new admission, is contingent upon agreement to repay payments received if the corrective action is not taken in accordance with the approved plan and timetable. It is also required that the nursing facility establish a directed plan of correction in conjunction with and acceptable to the Division of Aging.

(H) Upon execution of a Medicaid participation agreement, a qualified facility not previously certified for participation in the Medicaid Program shall be assigned a provider number by the Division. Facilities previously certified shall retain the same provider number and interim or prospective rate regardless of any change in ownership.

(I) Regardless of changes in control or ownership for any facility certified for participation in the Medicaid Program, the Division shall issue payments to the facility identified in the current Medicaid participation agreement. Regardless of changes in control or ownership for any facility certified for participation in Medicaid, the Division shall recover from that entity liabilities, sanctions and penalties pertaining to the Medicaid Program, regardless of when the services were rendered.

(J) Changes in ownership, management, control, operation, leasehold interest by whatever form for any facility previously certified for participation in the Medicaid program at any time that results in increased capital costs for the successor owner, management or leaseholder shall not be recognized for purposes of reimbursement;

(K) A facility with certified and non-certified beds shall allocate allowable costs related to the provision of nursing facility services on the cost report, in accordance with the cost report instructions. The methods for allocation must be supported by adequate accounting and/or statistical data necessary to evaluate the allocation method and its application.

(L) Any facility which is involuntarily terminated from participation in the Medicare Program shall also be terminated from participation in the Medicaid Program on the same date as the Medicare termination.

(M) No restrictions nor limitations shall, unless precluded by state plan, be placed on a recipient's right to select providers of his/her own choice.

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(N) The average Medicaid reimbursement rate paid shall not exceed the average private pay rate for the same period covered by the facility's Medicaid cost report. Any amount in excess will be subject to repayment and/or recoupment. The comparison of the average Medicaid reimbursement rate paid to the average private pay rate paid will not result in a repayment and/or recoupment until a facility has filed a cost report with a fiscal year ending after January 1, 1999. For example, a nursing facility with a December 31, 1998, year end cost report would not be used in the private pay rate comparison while a cost report ending on January 31, 1999, would be used in this comparison. This comparison will not be performed for any nursing facility licensed under Chapter 198, RSMo and operated by a district or county and receives local tax revenues.

(O) The reimbursement rates authorized by this plan shall be reevaluated at least on an annual basis in light of the provider's cost experience to determine any adjustments needed to assure coverage of cost increases that must be incurred by efficiently and economically operated providers.

(P) Covered supplies, such as but not limited to, food, laundry supplies, housekeeping supplies, linens, and medical supplies, must be accounted for through inventory accounts. Purchases shall be recorded as inventory and shall be expensed in the fiscal year the items are used. Inventory shall be counted at least annually to coincide with the facility's fiscal year or the end of the cost report period, if different. Expensing of items shall be recorded by adding purchases to the beginning period inventory and subtracting the end of the period inventory. This inventory control shall begin the first fiscal year ending after the effective date of this plan.

(Q) Medicaid reimbursement will not be paid for a Medicaid eligible resident while placed in a non-certified bed in a nursing facility.

(R) All illustrations and examples provided throughout this plan are for illustration purposes only and are not meant to be actual calculations.

(S) Each state fiscal year the Department shall submit to the Office of Administration for consideration a budget item based on the HCFA Market Basket Index for Nursing Homes representing a statistical measure of the change in costs of goods and services purchased by nursing facilities during the course of one year. An amendment to section (13)(A) Global Per Diem Adjustments of the state plan will be filed each year that will contain the specific details for each trend, including the amount, basis and effective date of the trend.

The submission of the budget item by the Department has no correlation to determining the costs that are incurred by an efficiently and economically operated facility. Any trend factor granted shall be applied to the patient care, ancillary and administration cost components. For facilities with allowable costs from their 1992 desk audited and/or field audited cost report as determined in sections (11), (12) and (13) of this plan that are below the facilities' January 1, 1994, reimbursement rate, any granted trend factor shall be limited to the product of the new plan rate divided by the January 1, 1994, (old plan rate) times the facility's trend factor. For example:

New Plan Rate (1-1-95)	$49.19
January 1, 1994, Rate	$54.32
Proposed Trend Factor	$ 1.88
Adjusted Trend Factor	$ 1.70

($49.19/$54.32) * $1.88
90.55% * $1.88 = $1.70

The rate after the trend would be $56.02 ($54.32+$1.70).

(T) Rebasing.

(1) The Division shall pick at least one cost report year from cost reports with fiscal years ending in 1995 through 1999 to compare the allowable costs from the selected desk audited and/or field audited cost report year to the reimbursement rate in effect at the time of the comparison. Each facilities' reimbursement rate will be increased or decreased to reflect the allowable

costs from the desk audited and/or field audited cost report selected above.

(2) The asset value will be adjusted annually based on the R. S. Means Construction Index. The asset value as adjusted will be used only for determining reimbursement in section (11) for the year or years selected above for rebasing and as determined in sections (13)(B)6. and (13)(B)7.

(4) Definitions.

(A) Additional Beds. Newly constructed beds never certified for Medicaid or never previously licensed by the Division of Aging or Department of Health.

(B) Administration. This cost component includes the following lines from the cost report version MSIR-1 (7-93): lines 105, 113-120, 122-140, 142-144, 147-150, 152-158 and amortization of organizational costs reported on line 106.

(C) Age of Beds. The age is determined by subtracting the initial licensing year from 1994 or the current year, if later.

(D) Allowable Cost. Those costs which are allowable for allocation to the Medicaid Program based upon the principles established in this plan. The allowability of costs shall be determined by the Division of Medical Services and shall be based upon criteria and principles included in this plan, the Medicare Provider Reimbursement Manual (HIM-15) and GAAP. Criteria and principles will be applied using this plan as the first source, the Medicare Provider Reimbursement Manual (HIM-15) as the second source and GAAP as the third source.

(E) Ancillary. This cost component includes the following lines from the cost report version MSIR-1 (7-93): lines 62-75, 87-95, 97-103, 145-146.

(F) Asset Value. The asset value of $32,330 per bed is used in calculating the Fair Rental Value System. The asset value consists of a bed cost and a land cost. The bed cost was based upon the national average cost of a nursing facility bed, without land cost, adjusted for the city index for Kansas City and St. Louis utilizing the 1994 R.S. Means Building Construction Cost Data. The land value was based upon a study of land costs for nursing facilities being approved for construction by the Certificate of Need program in Missouri.

(G) Average Private Pay Rate. The usual and customary charge for private patient determined by dividing total private patient days of care into private patient revenue net of contractual allowances and bad debt expense for the same service that is included in the Medicaid reimbursement rate. This excludes negotiated payment methodologies with State or Federal agencies such as the Veteran's Administration or the Missouri Department of Mental Health.

(H) Capital. This cost component will be calculated using a Fair Rental Value System. The fair rental value is reimbursed in lieu of the costs reported on lines 106-112 of the cost report version MSIR-1 (7-93) except for amortization of organizational costs.

(I) Capital Asset. A facility's building, building equipment, major moveable equipment, minor equipment, land, land improvements, and leasehold improvements as defined in HIM-15. Motor vehicles are excluded from this definition.

(J) Capital Asset Debt. The debt related to the capital assets as determined from the desk audited and/or field audited cost report.

(K) Ceiling. The ceiling is determined by applying a percentage to the median per diem for the patient care, ancillary and administration cost components. The percentage is 120% for patient care, 120% for ancillary and 110% for administration.

(L) Certified Bed. Any nursing facility or hospital based bed that is certified by the Division of Aging or Department of Health to participate in the Medicaid Program.

(M) Change of Ownership. A change in ownership, control, operator or leasehold interest, for any facility certified for participation in the Medicaid Program.

(N) Cost Components. The groupings of allowable costs used to calculate a facility's per diem rate. They are patient care, ancillary, capital and administration. In addition, a working capital allowance is provided.

(O) Cost Report. The Financial and Statistical Report for Nursing Facilities, required attachments as specified in paragraph (10)(A)8. of this plan and all worksheets supplied by the Division for this purpose. The cost report shall detail the cost of rendering both covered and non-covered services for the fiscal reporting period in accordance with this plan, cost report instruction and on forms or diskettes provided by and/or as approved by the Division.

(P) Databank. The data from the desk audited and/or field audited 1992 cost report excluding hospital based, state operated and pediatric nursing facilities. This data is adjusted for the HCFA Market Basket Index for 1993 of 3.9%, 1994 of 3.4% and nine months of 1995 of 3.3%, for a total adjustment of 10.6%. If a facility has more than one cost report with periods ending in calendar year 1992, the cost report covering a full twelve (12) month period ending in calendar year 1992 will be used. If none of the cost reports cover a full twelve (12) months, the cost report with the latest period ending in calendar year 1992 will be used. Any changes to the desk audited and/or field audited 1992 cost reports made after the effective date of this plan will not be included in the data bank.

(Q) Department. The Department, unless otherwise specified, refers to the Missouri Department of Social Services.

(R) Desk Audit. The Division of Medical Services' or its authorized agent's audit of a provider's cost report without a field audit.

(S) Director. The Director, unless otherwise specified, refers to the Director, Missouri Department of Social Services.

(T) Division of Aging. The Division of the Department of Social Services responsible for survey, certification and licensure as prescribed in Chapter 198 RSMo.

(U) Division. Unless otherwise specified, Division refers to the Division of Medical Services, the Division of the Department of Social Services charged with administration of Missouri's Medical Assistance (Medicaid) Program.

(V) Entity. Any natural person, corporation, business, partnership or any other fiduciary unit.

(W) Facility Asset Value. Total asset value less adjustment for age of beds.

(X) Facility Fiscal Year. A facility's twelve (12) month fiscal reporting period covering the same twelve (12) month period as its federal tax year.

(Y) Facility Size. The number of licensed nursing facility beds as determined from the desk audited and/or field audited cost report.

(Z) Fair Rental Value System. The methodology used to calculate the reimbursement of capital.

(AA) Field Audit. An on-site audit of the nursing facility's records performed by the Department or its authorized agent.

(BB) Generally Accepted Accounting Principles (GAAP). Accounting conventions, practices, methods, rules and procedures necessary to describe accepted accounting practice at a particular time as established by the authoritative body establishing such principles.

(CC) HCFA Market Basket Index. An index showing nursing home market basket indexes. The index is published quarterly by DRI/McGraw Hill. The table used in this plan is titled "DRI Health Care Cost - National Forecasts, HFCA Nursing Home without Capital Market Basket."

(DD) Hospital Based. Any nursing facility bed licensed and certified by the Department of Health.

(EE) Interim Rate. The interim rate is the sum of 100% of the patient care cost component ceiling, 90% of the ancillary and administration cost component ceilings, 95% of the median per diem for the capital cost component, and the working capital allowance using the interim rate cost component. The median per diem for capital will be determined from the capital component per diems of providers with prospective rates in effect on January 1, 1995.

(FF) Licensed Bed. Any Skilled Nursing Facility or Intermediate Care Facility bed meeting the licensing requirement of the Division of Aging or the Missouri Department of Health.

(GG) Median. The median cost is the middle value in a distribution, above and below which lie an equal number of values. This distribution is based on the databank.